Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
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1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

CERTIFICATE OF POSTGRADUATE TRAINING

MEDICAL EXAMINING BOARD

(Not necessary if utilizing FCVS)

IMPORTANT: *PLEASE FORWARD THIS FORM TO YOUR POSTGRADUATE TRAINING PROGRAMS (This form may be photocopied)*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

HOSPITAL NAME: _____

HOSPITAL ADDRESS: _____

HOSPITAL TELEPHONE: _____

1. In what type and level(s) of training did this physician participate at your facility? Check each level in which physician participated, provide starting and ending dates of his/her training in your program and type of training and whether credit was given for the training.

DATES (MO/YR)	SPECIALTY	CREDIT	NO CREDIT	PARTIAL CREDIT
_____ PGY 1 _____				
_____ PGY 2 _____				
_____ PGY 3 _____				
_____ PGY 4 _____				
_____ FELLOWSHIP _____				
_____ OTHER _____				

	YES	NO
2. Was the residency/fellowship accredited by ACGME of the AMA or AOA?	☐	☐
3. Did the physician complete the full training program in good standing? If no, please attach explanation on a separate sheet.	☐	☐
4. Was the physician asked to or required to repeat any portion of the training at your facility? If yes, please attach explanation on a separate sheet.	☐	☐

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		YES	NO
5.	Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
6.	Was this physician recommended for the Board Certification examination in this specialty?	☐	☐
7.	Was this physician granted a leave of absence while training at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
8.	Did this individual have a record of unexcused absences during his/her attendance at this training program?	☐	☐
9.	Were any restrictions and/or special requirements placed on this physician's activities that were not placed on all other residents/fellows at his/her level of training? If yes, please attach explanation on a separate sheet.	☐	☐
10.	Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet.	☐	☐
11.	Were any incident reports filed involving the professional behavior or conduct of this physician? If yes, please attach explanation on a separate sheet.	☐	☐
12.	Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
13.	Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
14.	Is there any additional information in this physician's file that would assist the Board in determining this applicant's eligibility for licensure. If yes, please attach explanation on a separate sheet.	☐	☐

Print name of Program Director _____

Signature of Program Director _____

Date form was completed _____

SEAL OF HOSPITAL

(If hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate)

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935